STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT GARDEN PLAZA	8614 W 10TH ST INDIANAPOLIS, IN 46234

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R0000	This visit was for the Investigation of Complaint IN00104178. Complaint IN00104178 - Substantiated. State deficiencies related to the allegations are cited at R0090, R0349, R0407. Date of Survey: April 3, 2012 Facility number: 005616 Provider number: 005616 AIM number: NA Survey Team: Mary Jane G. Fischer, RN Census bed type: Residential: 93 Total: 93 Census payor type: Other: 93 Total: 93 Sample: 4 Supplemental sample: 18 These state findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 5,	R0000	**The Bridge at Westside Garden Plaza** POC for Investigation of Complaint IN00104178 April 16, 2012 *Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	2012 by Bev Faulkner, R.N.			

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R0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be			

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	available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview, the facility failed to notify the State Agency of an unusual occurrence, in that when the facility had a flu like outbreak the Administrative staff failed to inform the State Agency of the extent of the outbreak, or specific actions that were taken to prevent further spread of the flu-like symptoms. This actually affected 21 residents with signs and symptoms of Norovirus, with the potential to affect all residents in the assisted living community. Findings include: During interview on 04-03-12 at 9:00 a.m., the Administrator indicated the facility had a "flu" outbreak in February [2012] and it "affected both the residential and independent living communities."	R0090	**A. With Respect to the Failure to Notify the State Agency of an Unusual Occurrence:** It had been reported to the Administrator that the Health Department had been notified and the miss communication was that the ***County Health Department*** was contacted rather than the ***State Department of Health***. Both the Administrator and the Resident Care Director have clarified their obligations to notify the State Department of Health within 24 hours of an epidemic outbreak. **B. With Respect to How the Facility will Identify Similar Reporting Obligations in the Future:** The facilities Infection Control Policy now states that an "epidemic outbreak" is defined as a contagious infection event that involves 20% of the census or more. Either the Administrator, or at their direction, the Resident Care Director shall report the occurrence to the State Department of Health. A Contagious Infection Tracking Log with a system on tracking all infectious illnesses has been	04/18/2012

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	The Administrator further indicated they notified the Marion County Health Department, who brought out a kit [used for samples], but by the time we got it, the outbreak was over. I don't think we have anything since that time." During interview on 04-03-12 at 9:30 a.m., the Resident Care Director indicated she was aware that 17 residents had gotten ill and by 02-20-12, she instructed the nursing staff to "quarantine" all residents to their rooms/apartments. The Resident Care Director indicated she notified the Marion County Health Department on 02-20-12 of the outbreak, but failed to notify the State Agency of the epidemic. Additional interview on 04-03-12 at 10:30 a.m., the Dietary Supervisor indicated that he as well as 1 or 2 servers and the "dessert lady" contracted the illness and were off work.		implemented to allow the staff to easily identify an epidemic outbreak. **C. With Respect to What Systemic Measures have been put in Place to Address the Stated Concern:** The Contagious Infection Tracking Log shall be a part of the daily shift change and reviewed at morning report. Nursing is instructed to report to the Resident Service Director, the Administrator, or their designate, any occurrence that equals or exceeds 20% of the resident census. The Resident Care Director has reviewed the Infection Control Policy and Procedures. The Resident Care Director will ensure clinical record documentation for residents' experiencing viral signs and symptoms, to include physician/family notification, interventions and resident response to the interventions. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** The Resident Care Director shall review the Contagious Infection Tracking Log on a weekly basis to assure that all contagious infections are being recorded and that there has not been an unusual occurrence of an epidemic outbreak that had not been reported to themselves, the Administrator or their designate.	

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	This State Finding relates to Complaint IN00104178.		This Plan of Correction will all be in place no later than April 20, 2012.	

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure complete clinical records, in that when residents contracted signs and symptoms of a virus, the nursing staff failed to document an assessment of the resident's condition in their clinical record for 1 of 3 residents sampled for the Noro Virus in a sample of 4 and 7 of 18 supplemental sampled residents. [Resident's "B", "H", "I", "J", "L", "N", "O" and "P"]. Findings include: During interview on 04-03-12 at 9:00 a.m., the Administrator indicated the facility had a "flu" outbreak in February [2012] and it "affected both the residential and	R0349	**A. With Respect to the Facility Failure to Ensure Complete Clinical Records:** An in-service will be held with nursing and dietary associates to review the management of epidemic outbreaks and clinical documentation requirements . **B. With Respect to How the Facility will Identify Similar Record Keeping Obligations in the Future:** The Resident Care Director shall spot check the individual resident charts against the Contagious Infection Tracking Log to assure that records are being maintained as required. This will be done as part of the weekly review of the Contagious Infection Tracking Log Infection Control education will be part of New Associate and Annual Orientation for nursing and dietary associates. **C. With Respect to What Systemic Measures have been put in Place to Address the**	04/18/2012

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	independent living communities." During interview on 04-03-12 at 9:30 a.m., the Resident Care Director indicated she was aware that 17 residents had gotten ill and by 02-20-12, she instructed the nursing staff to "quarantine" all residents to their rooms/apartments On 4-03-12, the Resident Care Director reviewed the 24 hour book and provided the names of the residents and the date the residents displayed signs and symptoms of the Noro-virus. The data was as follows: 02-16-12 Thursday - Resident's "B" contracted the virus. 02-17-12 Friday - Resident's "H", "I" and "J" contracted the virus. 02-19-12 Sunday - Resident's "L", "N", "O", and "P" contracted the virus.		**Stated Concern:** A sign off log will be used with the Contagious Infection Tracking Log to designate review by the Resident Care Director/designee assigned to the task in the absence of the Resident Care Director. The Infection Control Policy and Procedure Manual is accessible for the nursing and dietary associates. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** The signature log signed by the Resident Service Director on a weekly basis will serve as the measure that the Plan of Correction is being followed. This Plan of Correction will all be in place no later than April 20, 2012.	

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	During record review on 04-03-12 at 12:00 p.m., the clinical records for Resident's "B", "H", "I", "J", "L", "N", "O", and "P" lacked any information or assessment related to the viral outbreak. During interview on 04-03-12 at the Exit Conference, the Resident Care Director indicated she was aware the nursing staff failed to document in the resident's records signs or symptoms the residents had experienced during the virus outbreak. This State Finding relates to Complaint IN00104178.			

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R0407	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to have an effective infection control program, in that when the facility had a flu like outbreak [Noro virus], which included symptoms of nausea, vomiting and diarrhea, the facility failed to ensure a system was in place which included the implementation to track and monitor the surveillance of the epidemic for 1 of 1 infection control programs reviewed. This deficient practice effected 3 of 4 residents sampled for the Norovirus and 18 of 18 supplemental sampled residents but had the potential to effect the entire residential population at the	R0407	**A. With Respect to the Facility Failure to Establish an Infection Control Program that Includes the Following: A system to 1) Analyze, 2) Orientate and Educate, 3) Inform Residents and 4) Report to Health Authorities:** The Infection Control Manual Policy and Procedures have been reviewed by the Resident Care Director. The newly developed Contagious Infection Tracking Log has been added to the Policy and Procedure include the following: 1. The Log enables the facility to analyze patterns of known infectious symptoms. 2. The Manual includes an Infection Control Orientation for Nursing and Dietary Associates. 3. The Manual also includes General Resident Care that includes Resident and Family Education 4. The Log has established levels	04/18/2012

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	facility. [Residents "B", "C", "D", "E", "F", "G", "H", "I", "J", "K", "L", "M", "N", "O", "P", "Q", "S", "T","U", "V", and "W"]. Findings include: During interview on 04-03-12 at 9:00 a.m., the Administrator indicated the facility had a "flu" outbreak in February [2012] and it affected both the residential and independent living communities." The Administrator further indicated they notified the Marion County Health Department, who brought out a kit [used for samples], but by the time we got it, the outbreak was over. I don't think we have anything since that time." During interview on 04-03-12 at 9:30 a.m., the Resident Care Director indicated she was aware that 17 residents had gotten ill and by 02-20-12, and she instructed the nursing staff to "quarantine" all residents to their rooms/apartments.		at which time the staff is to inform both the Resident Care Director and the Administrator whom have been trained to notify the State Regulatory Office and State Department of Health of any epidemic occurrences. The outlined procedures shall be adhered to from this time forward. **B. With Respect to How the Facility Insure that these Procedures will be Maintained in the Future:** The continued education of the Infection Control and the Contagious Infection Tracking Log shall be part of the New Hire Orientation and In-Service training forl nursing and dietary associates. **C. With Respect to What Systemic Measures have been put in Place to Address the Stated Concern:** The Resident Care Director shall maintain a log of Orientation attendance and sign-in sheets for in-Services on Infection Control and the Contagious Infection Tracking Log. **D. With Respect to How the Plan of Corrective Measures will be Monitored:** The log of Orientation and In-Services on Infection Control and the Contagious Infection Tracking Log will be reviewed along with the Infection Control Manual by the Administrator on	

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	A request was made to review the facility infection control surveillance data. The Resident Care Director provided a document titled "Contagious Infection Tracking." This document contained 3 handwritten entries. Two of the entries indicated specific resident names who had been identified with Clostridium difficile colitis. The third handwritten entry indicated "Noro Virus - Feb. [February] 16 - 25 2012 - community stayed in apt. [apartment]." The document lacked any resident names, the first date the signs and symptoms were noticed, physician intervention and/or surveillance. The Resident Care Director indicated on 04-03-12 at 9:15 a.m., that although the "Contagious Infection Tracking" log was incomplete, the 24 hour book would contain the names of all the residents involved.		an annual basis. This Plan of Correction will all be in place no later than January 16, 2012.	

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	The Resident Care Director reviewed the 24 hour book and provided the names of the residents and the date the residents displayed signs and symptoms of the virus. The data was as follows: 02-16-12 Thursday - Resident's "B", "E" and "F" contracted the virus. 02-17-12 Friday - Resident's "G", "H", "I" and "J" contracted the virus. 02-18-12 Saturday - Resident "K" contracted the virus. 02-19-12 Sunday - Resident's "C", "D", "L", "M", "N", "O", "P" and "Q" contracted the virus. 02-20-12 Monday - Resident "S" contracted the virus. Although the 24 hour book identified the above residents with signs and symptoms of the Noro			

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	virus, the Resident Care Director indicated on 04-03-12 at 12:00 p.m., she was unaware that Residents "U" [contracted the virus on 02-18-12], "T" and "V" [contracted the virus on 02-19-12] and Resident "W" contracted the virus on 02-22-12. The Noro Virus effected 5 residents on the first floor, 8 residents on the second floor, and 8 residents on the third floor. Further interview on 04-03-12 at 10:00 a.m., the Resident Care Director indicated Residents "C" and "D" were hospitalized due to contracting the virus. During record review on 04-03-12 at 12:00 p.m., Resident's "M" and "Q" were sent to the hospital due to family concerns, and received intravenous fluids due to dehydration. Additional interview on 04-03-12 at 10:30 a.m., the Dietary			

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	Supervisor indicated that he [employee #5] as well as 1 or 2 servers and the "dessert lady" contracted the illness and were off work during the outbreak. Although the Resident Services Director indicated she had instructed the nursing staff to "quarantine" the residents to their room/apartment, this action was not taken until she was aware of 17 residents with signs and symptoms of the virus. During an interview on 04-03-12 at 9:53 a.m., a concerned family member indicated she as well as two additional family members contracted the virus after visiting with the resident over the weekend on 02-18-12. "It was such an outbreak, I was worried about the danger of it spreading." The Resident Services Director indicated she failed to notify the Medical Director "but his Nurse Practitioner came in to the facility			

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	on Tuesday [02-21-12] and that's when she found out about it. She [in reference to the Nurse Practitioner] didn't come back for her other visit that week, but returned to see the resident's the following week." The Resident Services Director indicated she notified the Marion County Health Department on 02-20-12 of the outbreak, but failed to notify the State Agency of the epidemic. This State Finding relates to Complaint IN00104178.			